SECTION II - STATEMENT OF APPLICANT *(Please answer every question, date and sign this statement)*

INFORMATION: The purpose of questions contained in STATEMENT OF APPLICANT is to secure complete information regarding the condition of the applicant's health. All diseases, injuries, abnormalities, deformities, or infirmities must be stated and fully described. Statements made by the applicant in this application are relied upon in granting insurance. Consequently, any deception or knowingly false statement either by inference, omission, or otherwise may result in cancellation of the insurance or in the refusal to pay a claim on the policy.

9A. ARE YOU NOW WORKING?	9B. DO YOU WORK FULL TIME?
☐ YES ☐ NO	☐ YES ☐ NO

9C. IF NOT WORKING OR WORKING PART-TIME, EXPLAIN WHY

10. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:

	YES	NO		YES	NO
A. DISEASE OF THE HEART OR ARTERIES; CHEST PAIN?			H. TUBERCULOSIS, PLEURISY, OR BRONCHITIS?		
B. HIGH BLOOD PRESSURE?			I. DIABETES?		
C. CANCER, TUMOR OR POLYP?			J. ARTHRITIS, PARALYSIS, OR DISEASE, OR DEFORMITY OF THE BONES, MUSCLES, OR JOINTS?		
D. LUNG DISEASE?			K. DISEASE OR ULCER OF STOMACH, INTESTINES, OR RECTUM?		
E. EPILEPSY, UNCONSCIOUSNESS, DIZZINESS OR IMPAIRMENT OF NERVOUS SYSTEM?			L. ANY DISEASE OF THE URINARY TRACT? SUGAR, ALBUMIN, OR BLOOD IN URINE?		
F. EMOTIONAL OR MENTAL DISORDER?			M. ANY DISEASE OF THE PROSTRATE OR TESTES IF A MALE; UTERUS, OVARIES OR BREASTS IF A FEMALE?		
G. DISEASE OF THE BLOOD?			N. DO YOU USE OR HAVE YOU BEEN TREATED FOR THE USE OF ALCOHOL OR ANY HABIT FORMING DRUG?		

11. WITHIN THE PAST 5 YEARS, HAVE YOU BEEN TREATED BY A PHYSICIAN?	12. ARE YOU NOW OR HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS, DISEASE OR INJURY?	13. DO YOU HAVE ANY SERVICE CONNECTED DISABILITIES?	14. HAVE YOU EVER APPLIED FOR DISABILITY COMPENSATION OR PENSION?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

15. HAS ANY APPLICATION YOU HAVE MADE FOR PRIVATE OR GOVERNMENT LIFE, HEALTH, DISABILITY OR ACCIDENT INSURANCE BEEN REFUSED, POSTPONED, APPROVED AT SUBSTANDARD RATES OR ON A DIFFERENT BASIS THAN APPLIED FOR?

☐ YES ☐ NO

16A. YOUR HEIGHT

FEET INCHES

16B. YOUR WEIGHT

POUNDS

17. REMARKS *(Give complete details to YES answers. Include dates, diagnosis, physicians or hospitals, and names and addresses. Indicate after each disability whether service-connected or nonservice connected. If additional space is needed, attach a separate sheet of paper)*

I consent that any hospital, physician or surgeon who has treated or examined me for any purpose, or whom I have consulted professionally may divulge to the Department of Veterans Affairs any information obtained by them, or it, concerning myself. I understand that the Government will rely on the truth of these answers. I HAVE READ THE ABOVE ANSWERS AND TO THE BEST OF MY KNOWLEDGE, THEY ARE TRUE.

I am obliged to advise the Department of Veterans Affairs of any change of health condition arising after the signing and prior to the delivery of this form to the Department of Veterans Affairs.

18A. SIGNATURE	18B. DATE

IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE CALL TOLL FREE 1-800-669-8477

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